

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38075**
Registrar's No. **9691**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Lutheran Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Days**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **Mary E. Ehrhardt**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased **December 6 1861**
(Month) (Day) (Year)

8. AGE: Years **86** Months **11** Days **0**
If less than one day hr. min.

9. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

12. Name **Bernhardt Reuter**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Wilson**
15. Birthplace **England**
(City, town, or county) (State or foreign country)

16. (a) Informant **Catherine Richter**
(b) Address **4973 A. Tholozan Ave**

17. (a) **Burial** (b) Date thereof **11-9-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Seigenthaler Bros**
(b) Address **6409 Gravois Ave**

19. (a) **J. B. Casser** (b) **J. B. Casser**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4973 A. Tholozan Ave**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6th** day **November**
year **1948** hour **8:05** minute **4** M.

21. I hereby certify that I attended the deceased from **September 1947** to **Nov 6 1948**
that I last saw her alive on **Nov 5 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage from Bladder** Duration **5 days**

Due to **malignant tumor of Bladder-Urinary**

Due to

Other conditions **Glaucoma bilateral**
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature **Chas. B. Benninger** (M. D. or other) **M.D.**
Address **3103 Avenue** Date signed **11/8/48**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,
working under my personal supervision.

Signed.....

Henry M. Brammer

Licensed Embalmer No.....

4200

P. O. Address.....

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.